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SUPREME COURT OF THE UNITED STATES.

OCTOBER TERM, 1931

No. 297

MRS. IRIS CHRISTINE BERGHOLM, ET AL.,
PETITIONERS,

vs.

PEORIA LIFE INSURANCE COMPANY OF PEORIA, ILL.

MOTION TO DISMISS.

JOHN M. ELLIOTT,
J. B. WOLFENBARGER,
ROSCOE WILSON,
J. I. KILPATRICK,
Counsel for Respondent.

SUPREME COURT OF THE UNITED STATES.

OCTOBER TERM, 1931

No. 297

MRS. IRIS CHRISTINE BERGHOLM, ET AL.,
PETITIONERS,

vs.

PEORIA LIFE INSURANCE COMPANY OF PEORIA, ILL., RESPONDENT.

RESPONDENT'S MOTION TO DISMISS WRIT OF CERTIORARI.

The respondent prays that the writ of certiorari be dismissed.

The recovery sought by the petitioners in this case is based upon a policy of insurance providing for certain disability benefits upon the happening of certain contingencies. The policy provides that failure to pay premiums automatically terminates the policy. Immediately following the benefits provided for in the policy is found this clause:

> To entitle the insured to the above total and permanent disability benefits, this policy, at the time of making claim for such benefits, must be in full force and all premiums becoming due prior to the time of making claim must have been duly paid by the insured.

This provision is set out in the opinion of the Circuit Court of Appeals and is found on page 196 of the Record.

The Circuit Court of Appeals in this case in its opinion stated that there was no evidence tending to prove the making of any claim for the benefit stipulated for until April 5, 1928 (Record 198), which was about seven months after the policy had lapsed. The Circuit Court held that the provision hereinbefore set out must be complied with and stated:

> As undisputed evidence showed that premiums were not paid within the time allowed, and there was evidence tending to prove that the insured did not do what the policy required to make the insurer subject to the liability asserted by this suit, the Court erred in giving to the jury the above mentioned instruction (Record 201).

Because of such error, the judgment was reversed and the cause remanded for a new trial (Record 201).

The respondent believes that this writ was improvidently granted since petitioners' petition did not reveal to this Court the foregoing provision and did not make it clear that the Circuit Court reversed and remanded the case for a new trial.

The holding of the Circuit Court of Appeals is not in conflict with the cases cited and relied upon by the petitioners for the allowance of the writ. The policies involved in those cases did not contain similar benefit clauses and contained nothing equivalent to the provision in this policy.

The holding of the Circuit Court is not in conflict

with the weight of authority as the petitioners have been unable to discover a case involving a similar provision.

Although this Court may have jurisdiction of this matter, it has been its custom and practice not to grant petitions for certiorari where the Circuit Court reversed and remanded the case except in a case of a clear conflict, and not usually then except in a case of extreme importance to the public or where public rights were involved, and not for the purpose of giving to the defeated party a second chance.

Authorities.

Chicago & Northwestern Railway Company v. *John Osborne*, 146 U. S. 354.

City of Omaha v. *Omaha Water Company*, 207 U. S. 585.

When in the progress of the case, it appears to this Court that the writ was improvidently granted, it will be dismissed.

Authority.

Furness, Withy & Company v. *Yanz-Tsze Insurance Association*, 242 U. S. 430.

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SUPREME COURT OF THE UNITED STATES.

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No. 297

MRS. IRIS CHRISTINE BERGHOLM ET AL.,
PETITIONERS,

vs.

PEORIA LIFE INSURANCE COMPANY OF PEORIA, ILLINOIS, RESPONDENT.

BRIEF FOR RESPONDENT.

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SUPREME COURT OF THE UNITED STATES.

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vs.

PEORIA LIFE INSURANCE COMPANY OF PEORIA, ILLINOIS, RESPONDENT.

BRIEF FOR RESPONDENT.

This case comes here on a writ of certiorari to the United States Circuit Court of Appeals for the Fifth Circuit; the writ was granted on the application of the petitioners. The petitioners filed with their petition a brief in support thereof, but have filed no additional brief since the granting of the writ.

The respondent has filed herein a motion to dismiss the writ and such motion has not been disposed of at the time of the filing of this brief, and this brief is submitted subject to such motion.

Statement of the Case.

The petitioners set out under subdivision A of their petition, beginning on page 1, a "Summary Statement of the Matter Involved". It is the opinion of the respondent that such statement omits matters that are material to the consideration of the questions presented, and respondent deems it necessary to correct such omissions by making a statement of the case.

On February 27, 1926, Carl Oscar Bergholm applied to respondent for a life insurance policy for $5,000, payable to Iris Christine Bergholm, wife of the insured, and one of the petitioners herein. The policy was written in consideration of the sum of $190.70, recited in the policy to be the premium for the first policy year ending February 27, 1927. The policy fixed the 27th day of February in every year during the continuance of the policy as the subsequent premium paying dates (R. 26 and 27). The policy provided that premiums might be paid annually, semi-annually or quarterly, according to the request of the insured (R. 30). By agreement of the parties, insured was permitted to change the method of payment from annually to quarterly. This is shown in paragraph 6 of the plaintiff's original petition, on page 17 of the Record. Attached to and forming a part of the policy was a rider showing that at the insured's request the death benefit should be payable in monthly installments of $50 each out of a trust fund to be formed by holding the proceeds of policy in trust (R. 32). The policy provided for a grace period of one (1) month of not less than thirty (30) days from any

due date (R. 31). The policy contained these provisions:

> "If any premium is not paid on the date when due, this policy shall cease and terminate as hereinafter provided" (R. 31).
>
> "If any premium after the first is not paid on the date when due, this policy will continue in full force from said date for a term of one (1) month of not less than thirty (30) days, which is the month of grace allowed hereunder * * *" (R. 31).

It further contained this provision:

> "This policy and the application therefor (a copy of which application is hereto attached) taken together constitute the entire contract" (R. 31).

It contained the further provision:

> "Only the president, vice-president, or secretary has power in behalf of the company to make or modify this or any contract of insurance, or to extend the time for paying any premium, and the company shall not be bound by any promise or representation heretofore or hereafter made unless made in writing by one of said officers" (R. 31-32).

Attached to the policy was a document entitled "Income Disability Clause", a portion of which is as follows:

> "Upon receipt by the Company of satisfactory proof that the Insured is totally and permanently disabled as hereinafter defined the Company will

1. Pay for the Insured all premiums becoming due hereon after the receipt of such proof and during the continuance of the total and permanent disability of the Insured and will also

2. Pay to the Insured a Monthly Income for life of 1 per cent of this Policy; the first payment of such income to be paid immediately upon receipt of such proof and subsequent payments to be made on the first day of each month thereafter as long as the Insured shall live and be totally and permanently disabled as hereinafter defined and" (R. 33).

This clause then states that the company will pay the face of the policy to the beneficiary upon receipt of due proof of the death of the insured (R. 33).

Immediatey following these provisions for disability benefits is set out this provision:

"TO ENTITLE THE INSURED TO THE ABOVE TOTAL AND PERMANENT DISABILITY BENEFITS, THIS POLICY, AT THE TIME OF MAKING CLAIM FOR SUCH BENEFITS, MUST BE IN FULL FORCE AND ALL PREMIUMS BECOMING DUE PRIOR TO THE TIME OF MAKING CLAIM MUST HAVE BEEN DULY PAID BY THE INSURED, * * *" (R. 33).

The petitioners sued for the disability benefits from September 1, 1927, to April 1, 1929, alleging that the insured was disabled for that period of time, at the end of which period he died, and for the amount of the face of the policy with 12 per cent penalty and $2,000 attorney's fees (R. 25).

As shown by testimony of the respondent's cashier, which is undisputed, the quarterly premium which

was due on the policy in February, 1927, was paid in March, 1927, and the quarterly premium which was due in May, 1927, was paid in June, 1927; no other premiums were ever paid on the policy (R. 168).

Correspondence between the respondent's State Manager and the insured and the insured's wife, one of the petitioners, was had throughout the year 1927 and on into 1928. Those introduced by the petitioners appear in the Record on pages 95 to 127, inclusive, and those introduced by the respondent appear in the Record on pages 145 to 162, inclusive.

At the trial of the case in the District Court of the United States for the Northern District of Texas, at Lubbock, presided over by Judge Wilson, the jury was instructed to return the verdict for the petitioners. The respondent assigned in several ways as error the action of the trial court in so instructing the jury and in refusing to instruct a verdict in favor of the respondent (R. 175). The respondent duly perfected its appeal to the United States Circuit Court of Appeals for the Fifth Circuit, which court reversed the judgment of the trial court and remanded the case for a new trial. The opinion of the Honorable Circuit Court of Appeals is shown in the Record, beginning at page 195.

The opinion of the circuit court in this case is here referred to as a complete statement of the case.

The holding of the circuit court may be summarized in one sentence of its opinion as follows:

> "As undisputed evidence showed that premiums were not paid within the time allowed, and there was evidence tending to prove that

the insured did not do what the policy required to make the insurer subject to the liability asserted by this suit, the court erred in giving to the jury the above mentioned instruction." (R. 200-201).

The circuit court reversed the judgment of the district court and remanded the case to the district court for a new trial (R. 201).

Summary of Argument.

The provision of the policy requiring that it shall be in full force at the time of making claim for benefits, and that premiums becoming due prior to the time of making claim be duly paid as hereinbefore set out, must be complied with in order to entitle the insured or his heirs to recover the disability benefits, and in order to keep the policy in force until the death of the insured. The statements made by the petitioners with reference to what the undisputed evidence reveals are not concurred in by the respondent, but, on the contrary, are denied. The authorities relied upon by petitioners do not involve policies in which similar disability clauses are found, and cannot be relied upon to set aside the express provisions in the contract involved in this case. The proof of the disability, if there was any disability, not having been made by Bergholm before his policy had lapsed for failure to pay premium, and while the policy was in full force, and the claim for disability benefits not having been made prior to the time of making default in the payment of his premiums, petitioners are precluded from any recovery. The statute authorizing

the recovery of attorney's fees and penalty is unconstitutional and the amount of attorney's fees recovered by petitioners in this case is excessive. The judgment of the circuit court should be affirmed.

ARGUMENT.

I

Reply to Petitioners' Assignment or Specification of Error.

The petitioners' assignment or specification of error is set out in the petition for the writ under the heading "Summary Statement of the Case Involved" and in the supporting brief under paragraph IV headed "Specifications of Error". In substance the petitioners' point is that the Honorable circuit court erred in reversing the judgment of the trial court and in holding that the clause hereinbefore set out required claim to be made and proof furnished while the policy was in full force and before default, was a condition precedent instead of construing the policy so that the insured should have a reasonable time for furnishing proof and making claim. The burden of the argument of petitioners is to the effect that the circuit court of appeals should have disregarded the plain and clear language of the contract and should have made a new and entirely different contract for the parties.

Respondent's contention is that such provision was a contract between the parties, that it is plain, clear and unambiguous, and that it was necessary that it

be complied with before any disability benefits could be recovered, and that the uncontroverted evidence shows, and the circuit court correctly found, that it was not complied with, and that the circuit court therefore did not err in reversing the judgment of the district court.

In the petition for this writ and in the supporting brief, the petitioners place upon parts of the opinion of the circuit court, and upon parts of the record in this case, unreasonable and unwarranted interpretations or constructions with which the respondent is unable to agree. At the outset, in the paragraph of the petition headed "Summary Statement of the Matter Involved", the petitioners contend that the respondent secured a reversal on the sole ground that the Income Disability Clause of the policy, obligating the insurer to waive payment of premiums and pay monthly disability benefit upon receipt by the company of satisfactory proof that the insured is totally and permanently disabled, was a condition precedent which must be complied with while the policy is in full force and before there is a failure to pay premium. The respondent respectfully submits that the clause quoted by petitioners is not the clause which was held by the Honorable circuit court of appeals to be a condition precedent, but that the clause following the description of the benefits, which has already been quoted and which required that the claim for the benefits and the proofs showing the right to such benefits must be made at a time when the policy was in full force and at a time when all premiums becoming due prior to the time of making the claim were paid, was a

condition precedent. Furthermore the petitioners have adopted and used the words "waive payment of premiums" both in page 2 and page 8 of their petition and brief. The policy does not provide that the premiums will be waived, but the company will pay for the insured all premiums becoming due after the receipt of such proof of total and permanent disability (R. 33). The Honorable circuit court said:

> "The language of that provision makes the making of such claim by the insured and the receipt of such proof by the appellant while the policy is in full force and before there is a failure to pay any premiums within the time allowed by other provisions of the policy, conditions precedent to the insured becoming entitled to the stated total and permanent disability benefits" (R. 199).

Under the same heading in the petition, petitioners state that the undisputed evidence showed the existence and continuance of such total and permanent disability during period stated, and respondent has never questioned the sufficiency of the proof of total and permanent disability, nor has it raised the question that satisfactory proof of disability was not made within a reasonable time. Respondent does now and has at all times insisted, not only that no proof of disability, as defined and required by the contract, was ever made, but that there was also no proof or suggestion of claim made prior to April 5, 1928, that the insured was at any time totally and permanently disabled, as required and defined in the contract. The respondent respectfully submits that as stated by the

Honorable Circuit Court of Appeals, "There was testimony tending to prove that the insured was totally and permanently disabled prior to September 27, 1927" (R. 198). The respondent denies that such fact was shown by undisputed evidence. The respondent insists that the letters hereinbefore referred to and parts of which will be hereinafter quoted dispute the testimony introduced by the petitioners tending to show that the insured was totally and permanently disabled. Respondent denies that there was ever any proof, satisfactory or otherwise, or any claim or suggestion of claim made to respondent or any of its representatives prior to the letter of April 5, 1928 (R. 153), which was many months after the policy had lapsed for the non-payment of the premium, which was due on August 27, 1927.

Certainly the respondent has to the best of its ability from the beginning of this case raised the question, not only as to any proof of disability before default in payment of the premium, but also as to the sufficiency of any alleged proof. This was raised in the respondent's answer upon which it went to trial, in paragraph 17 thereof (R. 44), and also paragraph 18 thereof (R.45) and in paragraph 20 thereof (R. 47) and in other parts of the answer. The question was raised again in the respondent's Assignments of Error, particularly in paragraphs 10 and 11 thereof (R. 178). The petitioners make a similar statement in their brief in support of their petition in Section 2, paragraph II, under the heading of "Jurisdiction".

In the petitioners' brief in support of their petition, paragraph IV, headed "Specification of Error",

the petitioners again state that the undisputed evidence showed that the grace period had not expired before September 27, 1927; that on said date the insured was wholly and permanently disabled within the meaning of the policy, and that on September 29, 1927, October 17, 1927, and November 10, 1927, the insurer denied liability and notified the insured the policy was forfeited. They refer to Record 121 and 122, and the respondent respectfully submits that the letters found on such pages in the record cannot be construed to have been intended as any denial of liability or a notice that the policy was forfeited, because at that time no question of liability had been raised. These letters were simply notices to the insured that the time for paying his quarterly premium had passed, and that the grace period had expired, and that his policy at that time was lapsed. The letters requested information as to why the premium had not been paid and sought to suggest plans to the insured by which the policy could be reinstated, and indicate an effort and a desire on the part of the respondent to place the policy in force; otherwise it may be inferred that it would have made no suggestion, much less a persistent effort to induce the insured to reinstate his policy.

In the same paragraph in their brief, the petitioners quote parts of sentences found in letters written, and the respondent respectfully submits that the letter as a whole and certainly the complete sentence should be read in order that their meaning might be obtained. The parts that are quoted are from the letter of September 26, 1927 (R. 149-150-151-152). This

letter was written by Mrs. Bergholm to Mr. Stamp, the State Manager in Charge of Production. She states in this letter:

(1) "I am surely sorry Oscar has not settled for the note. I have talked to him and he has promised to try to make a settlement when he gets paid for directing the band, which he has been taking care of until a new director arrives. He does not know what he will receive, however. He has also said he would send some of the notes he cannot get a settlement for.

(2) It is impossible for me to send you my personal check this month or I would do so. I hope to be able to get Oscar to take care of this. It seems that it takes every penny of my salary for us to live on. If he does not make a decided change I do not know what is to become of us.

(3) I do not like to complain but it seems that things get worse all along. I wonder sometimes if he will ever do anything with life insurance. Three years is a long time to try and make so little sign."

And further on she says:

(4) "I know Oscar's is due or perhaps past due. If it is not too late I can send 10% of his and Adele's this week end but it will be impossible for me to pay any quarterly premiums now. For Adele's sake, I would like to have them kept in force. I suppose, though, I am foolish to try to pay the premiums. If you think I am, never mind about writing in regard to them.

(5) If Oscar wanted to badly enough I think he could make enough to at least keep his af-

fairs straight and pay his insurance, when all my money goes for expenses and debts."

And further:

(6) "I have often thought of asking you to talk to him about quitting this work. He knows life insurance, I think, but some how he just does not sell it. I think one of his mistakes is in not planning his work systematically.

(7) Do you really think he should stay with the work? I am frank to admit that I have tried to get him to find something else to do."

As stated by the petitioners, this letter was written just one day before the grace period expired and there is not a single statement in it which intimates that there is any contemplation of total and permanent disability or of any existing claim therefor. The fifth and sixth clauses or paragraphs of the letter above quoted, numbered by respondent for convenience, shows that on the date of said letter Mrs. Bergholm, who wrote the letter and who is one of the petitioners, was of the opinion that her husband was able to make enough to keep his affairs straight and pay his insurance if he would make an effort to do so; that Bergholm knew life insurance, and that, in her opinion, the thing that stood in the way of his success was he did not plan and pursue his work systematically. There was no intimation of even a temporary disability, much less a total and permanent disability. She also states in that letter: "Three years is a long time to try and make so little sign", clearly indicating that his failure to succeed in life insurance was not due to physical

disability, but to other causes mentioned in the letter.

In other letters written from time to time during the year 1927 by the insured to his superior officer, Thomas A. Stamp, State Manager, the insured reported that he was looking after the company's business, enclosed a few remittances, and stated that at times he was ill. On April 11, 1927, he wrote, enclosed his check for $2.00 as a part payment on a premium collected by him from another insured, requested some blanks, referred with pleasure to a trip he had had to Dallas, and stated that his daughter was ill (R. 146). No mention is made of any illness of his own. On August 19, 1927, he wrote, enclosed an agency contract which he had obtained and advised that he would work with the agent from time to time and try to help him along (R. 147). This was eight days before the defaulted premium became due, and instead of this letter being proof of illness or disability, it would indicate to the ordinary mind that the insured was going about his business. On September 8, 1927, after the due date of the defaulted premium, but during the grace period, he wrote to Mr. Otta, enclosed check to cover annual premium of Harvey Byars, and requested receipt (R. 147). Still no mention is made of any illness or disability. On September 25, 1927, two days before his grace period expired, he wrote at length reporting on various prospects and customers, enclosed a note of one of the company's debtors, stated that he would see another one by Tuesday night, and that he was trying to find two others, and stated:

> "Doing a little work now and hope to Pete I'll be able to stand up. The M. D.'s don't

know where I'll end up as yet and just want us to be careful.

The premium on my policy will be due in a day or two. Want to keep it in the worst way but the rub is I cannot pay the next quarterly premium. In fact we are so broke we don't know where the next meal is coming from. If there is some way to give a note, we will do all we can to meet it as well as take care of notes now due you."

And still further in this letter:

"Hope to be in shape to go and work with Mr. Kennedy at Hale Center some day this week. This will be all night work as he does not get through before six and I am prohibited to go out in the night air. Will have to, however" (R. 148-149).

The respondent respectfully submits that no trace of any proof of total and permanent disability as contemplated by the policy can be found in this letter, and the letter affirmatively indicates that the insured had no intention of making any claim for benefits at that time. As stated, this letter was written two days before the grace period and one day before his wife, one of the petitioners, wrote the letter of September 26th, hereinbefore quoted from. Several months later on December 31, 1927 (R. 152), and on January 26, 1928 (R. 153), the insured was writing again regarding business that he was doing and in the December letter enclosed checks to cover some collections that he had made.

On April 5, 1928, Mrs. Bergholm wrote to Mr. Stamp, and at this time she inquired about the disability benefits. The letter follows, but, before quoting it, attention is called to the fact that it was written nearly seven months after the grace period had expired following the due date of the quarterly premium due August 27, 1927.

"PLAINVIEW, TEXAS, *April* 5, 1928.

Mr. Thomas A. Stamp,
Dallas, Texas.

DEAR MR. STAMP:

I am just wondering if Oscar cannot collect on the disability part of his policy. I tried to get him to make a claim last summer but he would not because he believed it would permanently bar him from taking out any more life insurance, if he collected on a disability clause. He was disabled for a good deal longer than three months and from what the doctors say it could easily be called disability from the time of his trouble last year.

I talked to Oscar about it and he is of the opinion that he is entitled to it.

I do know he has not been able to work for a long time. He was in bed for about two months last year and for two or three months he was up and down. He would walk down town and back and be almost exhausted. The doctor told him all along not to work, but he felt that he had to, and would attempt it, but without success as you know.

It has been discouraging to me at times but I have tried to be patient for I knew he was not well.

Please let me know if he is entitled to any benefits, for we surely are in need of money.

This long spell of sickness is what kept us from being able to pay the last premium, however it began several months previous to the time the premium was due.

Thanking you for any advice you may offer, I am,

Yours truly,

MRS. C. O. BERGHOLM. (R. 153-154.)

In reply to that letter, she was advised by Mr. Stamp that the policy provided that to entitle the insured to disability benefits the policy at the time of making claim must be in full force and all premiums due prior to the time of making claim must have been paid, and she was further advised that only two quarterly premiums were paid on the second year of the policy, and that it had, therefore, expired (R. 124).

The petitioners introduced at great length testimony tending to show that from the time the next preceding letter was written until the death of the insured, in April, 1929, he was totally incapacitated. They spared no detail to show the intense suffering that he went through and the resultant hardships suffered by his family. No further proof is offered showing any requests for proofs of any kind until after the death of the insured.

The respondent has set out at length the foregoing portions of the record in view of the recent holdings of this Honorable Court that in a case coming to it by certiorari the entire record is before the court and

the court should and will make such disposition of the case as should have been made, and since the record is to be examined it seems proper to the respondent that it should be referred to in its brief. Practically all of the foregoing statement is excellently summarized in one paragraph of the opinion of the Honorable Circuit Court of Appeals, as follows:

> "Evidence adduced in the trial showed that at the time the policy was issued the insured was appellant's District Manager at Plainview, Texas, his duties being to solicit and write life insurance for the appellant, to employ agents, to look after the appellant's business and build it up in that part of Texas; that the insured held that position throughout the year 1927, and during the summer and fall of that year and until after the expiration of it, engaged in correspondence in reference to the business of such agency, with Thomas A. Stamp, the State Manager, for Texas, of the appellant, who was located at Dallas, Texas; that in the course of that correspondence, and also in letters written during that time by the insured's wife to Mr. Stamp, mention was made of the fact that the insured was or had been sick and unable to work; but there was no statement or suggestion in that correspondence that the insured was totally and permanently disabled as defined in the above set out provision. In the trial there was testimony tending to prove that the insured was totally and permanently disabled prior to September 27, 1927, and that such disability continued until his death. There was no evidence tending to prove the making of any claim for the benefits stipulated for in the above set out provision prior to the date of the following

letter written by the insured's wife, the beneficiary:'' (here Mrs. Bergholm's letter of April 5th is copied) (R. 197-198).

It is respectfully submitted that the record shows conclusively that both the insured and his wife had plenty of time and opportunity to present to the respondent through its proper officers proof of his disability, if it existed, and a claim for the benefits by reason thereof. They could write about anything else that they desired and did so. The insured was an experienced insurance man, selected this policy for himself and sold it to himself, and must have known what it contained. His reason for not paying his premium on September 25, 1927, as shown by his letter quoted above, was that he did not have the money, and not that he was disabled.

The petitioners, for the purpose of sustaining their petition for the writ and as authority for reversal of the Circuit Court holding in this case, rely largely, if not exclusively, on the case of *Minnesota Mutual Life Insurance Company* v. *Marshall,* decided by the Circuit Court, and on the case of *State Life Insurance Company* v. *Fann,* decided by the Court of Civil Appeals for the Seventh Supreme Judicial District of Texas. The petitioners state that these cases involved policies containing benefit clauses similar to the one involved in this case. The respondent respectfully submits that in neither of the policies involved in those cases was there any provision similar to the one in the Bergholm policy.

In the Minnesota Mutual Life Insurance Company case, the Circuit Court stated:

> "The policy provided that if the insured while the policy is in full force and effect and without default in the payment of premiums, 'shall become totally and permanently disabled as hereinafter provided and shall furnish satisfactory proof thereof, the company will waive the payment of premiums thereafter becoming due. * * *
>
> Second. Upon the receipt of due proof of total and permanent disability, as above defined, the company will waive the payment of all premiums thereafter becoming due' ". Minnesota Mutual Life Insurance Company *vs.* Marshall, 29 Federal (2d) 977.

That policy did not expressly require any proof to be made or any claim submitted before default in the payment of premiums and while the policy was in full force and effect. The Bergholm policy did require this. In the Minnesota Mutual Life Insurance Company case the fact of the existence of the disability before default and not the proof thereof is the test of the liability; in the case at bar, the test of liability is not only the existence of the disability, but also the making of proofs of claim and the making of the claim before default. No claim or suggestion of a claim was made prior to April 5, 1928, and the policy lapsed on September 27, 1927, at the expiration of the grace period, for failure to pay the premium due August 27, 1927. There is no evidence in the case that any information coming to respondent from any source whatever showed that the insured was totally and permanently disabled before default, and the respondent

relies on the contract of insurance, in which it is plainly and clearly stated that proofs of claim showing total and permanent disability, as defined in the contract, must be made before default in the payment of any premium, in order to establish the right to claim any of the disability benefits.

The Supreme Court of Pennsylvania in the case of *Brams* v. *New York Life Insurance Company*, 299 Pa. 11 (148 Atlantic 855), decided January 6, 1930, distinguished the case of *Minnesota Mutual Life Insurance Company* v. *Marshall* from the case under consideration by that Court, and said, in substance, that the Marshall case required no formal proof of incapacity at any particular time, whereas in the Brams case, under consideration by the Pennsylvania Supreme Court, the policy required that the proof be made before default. The policy which was being considered by the Pennsylvania Court contained the following provision:

> "Upon receipt of the Company's Home Office, before default in payment of premium, of due proof that the insured is totally disabled, as above defined, and will be continuously so totally disabled for life * * * the following benefits will be granted."

The policy also provided for certain times on which premiums should be paid, and that if a premium was not paid on or before its due date and within the grace period, the policy would not be extended past such due date. The insured in that policy failed to pay a premium which was due on August 11th. On September 6th, the insured's sister wrote the company that the

insured was sick and would pay his premium as soon as he got well. No notice of disability then existing was furnished, and the premium was never paid. The insured died on November 21st, and a claim was made on his policy. The Supreme Court of Pennsylvania held that the letter written by his sister was not a compliance with the provisions of the contract, and that the insured and his beneficiary were bound to have made the proof prior to default. *Brams* v. *New York Life Insurance Company,* 299 Pa. 11. The disability clause in the Brams policy and the disability clause in the Bergholm policy are almost identical so far as the requirement that proofs of disability must be received by the company before default in the payment of premiums. The Marshall case and the Fann case, principally relied upon by petitioners, have no application to the case at bar, and the test of liability in those cases was not and is not the test of liability in the case at bar.

Similar decisions have been made by the Supreme Court of Washington. *Jones* v. *New York Life Insurance Company,* 158 Washington 12; *Wick* v. *Western Union Life Insurance Company,* 104 Washington 129.

In the Fann case, relied upon by the petitioners, the policy contained the following disability clause headed "Total and Permanent Disability":

> "If the insured, after paying at least one full annual premium and before default in the payment of any subsequent premium and before attaining the age of 60 years, shall become wholly and permanently disabled by bodily injury or by disease so that he is or will be permanently, continuously and wholly prevented

thereby from performing any work for compensation or profit, or from following any gainful occupation, the company, upon receipt, at its home office of due proof of such disability of the insured as may be required by the company, will grant the following benefits: First. Will waive payment of premiums thereafter becoming due. Second. In addition will pay to the insured a monthly income equal to all of the original amount of insurance (exclusive of any accidental death benefit). The first monthly payment will be made upon satisfactory proof of disability as above provided, and the subsequent monthly payments will be made on the first day of each month thereafter during such disability."

The Court of Civil Appeals for the Seventh Supreme Judicial District of Texas held that the insured having become insane before his policy lapsed, he was entitled to recover and quoted another Texas case as follows:

> "It did not appear from the forfeiture clause or any part of the policy that the proof request and waiver referred to must have been made before the expiration of the 31 days specified. On the contrary, the time when the insured was to make such proof was not limited by anything in the policy." State Life Insurance Company *vs.* Fann, 269 S. W. 1111, quoting Merchants Life Insurance Company *vs.* Clark, 256 S. W. 969 (Texarkana Court of Civil Appeals)..

The petitioners assert that the holding of the Circuit Court of Appeals in this case is in conflict with the Minnesota Mutual Life Insurance Company case,

the Fann case, and with the weight of authorities shown by several other cases. They then state: "The decisions referred to disclose that the modern forms of private health and accident insurance usually contain the disability clause in question." The respondent respectfully submits that in none of the cases cited by petitioners was there involved a policy containing a provision like the one in the Bergholm policy, which definitely and expressly, without ambiguity, requires proof to be made and claim filed while the policy is in full force and effect, and before default in the payment of any premium. As a matter of fact, the disability clause in the Bergholm policy is unlike and dissimilar, both in form and legal effect, to the disability clauses found in the policies involved in any and all of the cases cited and relied upon by petitioners.

The Marshall case and the Fann case, relied upon by the petitioners, are not in conflict with the decision of the Circuit Court of Appeals in this case, and the reason therefor is plain and clear. They arise out of and are based upon disability clauses entirely different in phraseology and requirements or in acts to be done or performed by the insured, as the respondent has shown.

The disability clause in the Bergholm policy is not ambiguous and the ordinary layman can understand it. Certainly Bergholm, who had been engaged for three years in selling the policy himself (R. 150), had no doubt about its meaning. It was a part of the contract.

It is well settled that prompt payment of premiums in insurance policies is essential and when the policy fixes the time for such payments and provides that failure to pay terminates the policy, such provision is a part of the contract and is enforceable, and where there is any exception to such requirement, one claiming under the policy must show that his claim is within such exception.

Klein v. New York Life Insurance Co., 104 U. S. 88.

Thompson v. *Knickerbocker Life Insurance Co.*, 104 U. S. 252.

Pilot Life Insurance Co. v. *Owen*, 31 Fed. (2d) 862.

Such provisions have been enforced by the Supreme Court of Texas.

Brotherhood of Railway Trainmen v. *Dee*, 101 Texas 596.

Sun Mutual Insurance Co. v. *Mattingly*, 77 Texas 162.

Burns v. *American National Insurance Co.*, 280 S. W. 762 (Com. App.).

Continental Casualty Co. v. *Wade*, 101 Texas 102.

Home Insurance Company v. *Puckett*, 27 S. W. (2d) 111. (Com. App.)

The respondent submits that in addition to the authorities already referred to those listed below sustain its contention that the judgment of the Circuit Court should be affirmed.

New York Life Insurance Co. v. *Statham*, 93 U. S. 24.

McCampbell v. *New York Life Insurance Co.*, 288 Fed. 465.
(5th Circuit) Certiorari denied, 262 U. S. 759.

Sellers v. *Continental Life Insurance Co.*, 30 Fed. (2d) 42.

Long v. *Monarch Accident Insurance Co.*, 30 Fed. (2d) 929.

Courson v. *New York Life Insurance Co.*, 295 Pa. 518.

New England Mutual Life Insuarnce Co. v. *Reynolds*, 217 Ala. 307.

Griffin v. *Northwestern Mutual Life Insurance Co.*, 250 Mich. 185.

The theme of the petitioners' petition for this writ and their supporting brief is that the Circuit Court erred in holding that the compliance of the insured with the terms of the contract is a condition precedent to the right of recovery. The Circuit Court was correct in this holding. The question is not an open one in this Court. This Court has held:

> "The compliance of the assured with the terms of the contract is a condition precedent to the right of recovery. If the assured has violated, or failed to perform the conditions of the contract, and such violation or want of performance has not been waived by the insurer, then the assured cannot recover. It is immaterial to consider the reasons for the conditions of provisions on which the contract is made to terminate, or any other provision of the polic which has been accepted and agreed upon.

is enough that the parties have made certain terms, conditions on which their contract shall continue or terminate. The courts may not make a contract for the parties. Their function and duty consist simply in enforcing and carrying out the one actually made." Imperial Fire Insurance Company *vs.* County of Coos, 151 U. S. 452.

II.

Additional Grounds for Affirmance of the Action of the Honorable Circuit Court of Appeals in Reversing the Case.

1. The uncontroverted evidence showing that no proof of disability and that no claim for disability benefits were made while the policy was in full force and effect and before default in the payment of the quarterly premium, which was due on August 27, 1927, and the policy providing that failure to pay terminated the policy, and the benefit clause providing that proof and claim must be made at such times, the trial court should have instructed a verdict in favor of the respondent, and should have rendered judgment in favor of the respondent, and erred in failing to do so.

2. The trial court erred in permitting a recovery by the petitioners of the sum of $2,000.00, attorney's fees, and 12 per cent penalty because the statute of Texas providing for same is unconstitutional, in that it violates the due process of law and equal protection clauses of the Constitution of the United States.

3. The sum of $2,000.00, attorney's fees, is excessive.

The foregoing were assigned as error in various ways in respondent's assignments of error filed in the trial court (R. 175). It is true that none of the assignments expressly attack the constitutionality of the statute mentioned. However, the point has been sufficiently raised by general denial, assignments of error, and a presentment of the question to the Circuit Court.

The first additional point hereinbefore set out is sufficiently covered by argument in reply to the petitioners.

As to the constitutionality of the statute, the statute relied upon by the petitioners to support their recovery of attorney's fees and 12 percent penalty is Article 4736 of the Revised Civil Statutes of Texas, which provides as follows:

> "In all cases where a loss occurs and the life insurance company, or accident insurance company, or life and accident, health and accident, or life, health and accident insurance company liable thereunder, shall fail to pay the same within 30 days after demand therefor, such company shall be liable to pay the holder of such policy, in addition to the amount of the loss 12 percent damages on the amount of such loss, together with reasonable attorney's fees for the prosecution and collection of such loss."

This Court has held that to apply this statute to a policy or contract entered into in another State would be a violation of the United States Constitution. *Aetna Life Insurance Company* v. *Dunken*, 266 U. S. 389.

The respondent is fully aware that this very statute has been held constitutional by this Court in the case

of *Fidelity Mutual Life Insurance Company* v. *Mettler*, 185 U. S. 308, and also in *Iowa Life Insurance Company* v. *Lewis*, 187 U. S. 335. However, in the Mettler case, Justice Harlan dissented, and it is believed by some members of the bar that this Court has overruled, or at least denied, the principle on which they were decided in the more recent case of *Terral* v. *Burke Construction Company*, 257 U. S. 529. This contention was made in a brief for the appellant on the constitutionality of a similar Arkansas statute in the case of *Inter-Southern Life Insurance Company* v. *McElroy*, 38 Federal (2d) 557. The Circuit Court of Appeals for the Eighth Circuit in deciding the case stated that unless the statute could be construed as one imposing a penalty for vexatious refusal to pay and not one which simply penalized litigation on a question of liability about which lawyers might honestly entertain different opinions, the statute was violative of the due process of law and equal protection of the law clauses of the Constitution of the United States.

The only witness who testified as to the reasonableness of the fee was one of the attorneys for the petitioners, whose testimony showed that he had in mind a contingent fee. It has been held that this statute does not contemplate a contingent fee. *Southland Life Insurance Company* v. *Norton*, 5 S. W. (2d) 767. (Comm. App.)

It has been held that a judgment for $5,000.00 attorney's fees on a policy for $10,000.00 was excessive (*Id.*).

Conclusion.

The judgment of the Honorable Circuit Court of Appeals for the Fifth Circuit should be affirmed, or judgment for the respondent should be rendered.

Respectfully submitted,

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